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Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,
Petitioners,

v.

STUART CIRCLE HOSPITAL CORPORATION,
Respondent.

On Petition For Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

The Employee Retirement Income Security Act of 1974 ("ERISA") preempts all state laws that relate to employee benefit plans, with a limited exception for laws that regulate insurance. The question presented in this case is:

Whether a state law that mandates only which health care providers must be included in a preferred provider organization used by an employee benefit plan to deliver health care services, but not what services must be provided to plan participants, is saved from preemption under ERISA because it regulates the "business of insurance."

LIST OF PARTIES

All parties are listed in the caption. Pursuant to Rule 29.1, petitioners Aetna Life Insurance Company and Aetna Health Management provides the following list of parent corporations and non-wholly owned subsidiaries: Aetna Life and Casualty Company, Med Southwest, Inc., HEALTHWAYS, Inc., Aetna Health Plans of San Diego, Inc., Aetna Health Plans of Colorado, Inc., PHPSNE Parent Corporation, Aetna Health Plans of Florida, Inc., and PARTNERS Health Plan of Pennsylvania, Inc.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
LIST OF PARTIES	ii
TABLE OF CONTENTS	iii
TABLE OF AUTHORITIES	iv
OPINIONS AND ORDERS BELOW	1
JURISDICTION	2
STATUTORY PROVISIONS INVOLVED	2
STATEMENT OF THE CASE	2
REASONS FOR GRANTING THE WRIT	7
A. The Fourth Circuit's Decision Will Have Profound Adverse Consequences for the Efficient Delivery of Health Care, in Direct Contravention of the ERISA Mandate	8
B. The Fourth Circuit's Decision is Directly Contrary to Supreme Court Authority and Is Inconsistent with the Third Circuit's Recent Decision in *Ticor Title Ins. Co. v. FTC*	15
1. The Fourth Circuit Failed to Heed the Lesson of *Royal Drug* that the Selection of Service Providers Is Not the "Business of Insurance"	16
2. The Fourth Circuit's Decision Is in Conflict with the Third Circuit's Decision in *Ticor* in Its Reading of the "Business of Insurance"	22
C. The Issue in This Case is Too Important to Wait for a Direct Split of Lower Court Authority	24
CONCLUSION	26

TABLE OF AUTHORITIES

Cases:

Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 (1981) 9

American Medical Association, 94 F.T.C. 701 (1979) *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court*, 455 U.S. 676 (1982) 15

Blue Cross and Blue Shield of Kansas City v. Bell, 798 F.2d 1331 (10th Cir. 1986) 24

Blue Cross Hospital Service of Missouri v. Frappier, 698 S.W.2d 326 (Mo. 1985) 24

Blue Cross and Blue Shield of Virginia v. St. Mary's Hospital of Richmond, 245 Va. 24, 426 S.E.2d 117 (1993) 25

Eugene M. Addison, M.D., 111 F.T.C. 339 (1988) 15

FMC Corp. v. Holliday, 111 S. Ct. 403 (1990) 8

Fort Halifax Packing Co. v. Coyne, 482 U.S. 1 (1987) 9,11

Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979), *cert. denied*, 469 U.S. 1160 (1985) 5,18,19,20

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Medical Service Corp. of Spokane County, 88 F.T.C. 906 (1976) 15

Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985) 6,15,16,21,22

Moore v. Metropolitan Life Ins. Co., 856 F.2d 488 (2d Cir. 1988) 9-10

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) 9,15,16,22

Table of Authorities Continued

	Page
SEC v. Variable Annuity Life Ins. Co., 359 U.S. 65 (1959)	16
Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983)	9
Ticor Title Ins. Co. v. FTC, 998 F.2d 1129 (3d Cir. 1993)	7,22,23
Tingle v. Pacific Mutual Ins. Co., 996 F.2d 105 (5th Cir. 1993)	23
United States Dept. of Treasury v. Fabe, 113 S. Ct. 2202 (1993)	19
Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981)	6,25

Statutes:

Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.*	*passim*
29 U.S.C. § 1001(a)	9
29 U.S.C. § 1051(1)	9
29 U.S.C. § 1081(1)	9
29 U.S.C. § 1144(b)	15
McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*	*passim*
28 U.S.C. § 1254(1)	2
28 U.S.C. § 1441(a)	4
Ala. Code § 27-45-3 (Supp. 1993)	10
Ark. Ins. Comm. Bulletin 9-85 & 9-85A (1985)	10
Ga. Code Ann. § 33-20-16 (1990)	10
Idaho Code § 41-1844 (1991)	10
215 Ill. Comp. Stat. Ann. 5/370h (1993)	10
Ind. Code Ann. § 27-8-11-3 (Burns 1992)	10

Table of Authorities Continued

	Page
La. Rev. Stat. Ann. § 40:2202 (West 1992)	10
Neb. Rev. Stat. § 44-4112 (1988)	10
Nev. Rev. Stat. Ann. §§ 695C.177, 695C.178 (1986)	10
S.D. Codified Laws Ann. § 58-18-37 (1990)	10
Utah Code. Ann. § 31A-22-617 (1991)	10
Va. Code § 38.2-3407 (1993)	*passim*
W. Va. Code § 33-25A-31 (1992)	10
Wis. Stat. Ann. § 628.36 (1991 & Supp. 1992)	10
Wyo. Stat. § 26-22-503 (1977)	10

Other Authorities:

American Association of Preferred Provider Organizations (1993)	11
David Dranove, et al., *Is Hospital Competition Wasteful?*, 23 RAND J. Econ. 247 (Summer 1992)	13
Jon B. Christianson & Walter McClure, *Developing a Regulatory/Strategy Consistent with a Competitive Health Care System, in Socioeconomic Issues of Health* 104 (Douglas E. Hough & Glen I. Misek eds., 1980)	13
G.A. Melnick, et al., *The Effects of Market Structure and Bargaining Position on Hospital Prices*, 11 J. Health Econ. 217 (1992)	13
Elizabeth S. Rolph, Paul B. Ginsburg & Susan D. Hosek, *The Regulation of Preferred Provider Organizations*, 6 Health Affairs 32 (Fall 1987)	14
Elizabeth S. Rolph, et al., *State Laws and Regulations Governing Preferred Provider Organizations* (Rand 1986)	11,12

Table of Authorities Continued

Page

Lori A. Tobias, *Cost v. Quality in the Regulation of Preferred Provider Arrangements: A "Green Light to the Gold Rushs"?*, 41 Sw. L.J. 1155 (1988) 12

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PETITION FOR WRIT OF CERTIORARI

Aetna Life Insurance Company and Aetna Health Management (collectively "Aetna") hereby petition this Court for a writ of certiorari to review the judgment in this case of the United States Court of Appeals for the Fourth Circuit.

OPINIONS AND ORDERS BELOW

The July 1, 1993 order of the Fourth Circuit denying Aetna's petition for rehearing and suggestion for rehearing in banc is unreported and is reproduced at App. 1a-2a. That court's June 2, 1993 opinion is

reported at 995 F.2d 500 and is reproduced at App. 3a-13a. The July 22, 1992 memorandum opinion of the United States District Court for the Eastern District of Virginia is unreported and is reproduced at App. 14a-32a.

JURISDICTION

The Fourth Circuit entered judgment in this case on June 2, 1993, and denied Aetna's timely petition for rehearing on July 1, 1993. This petition is being filed within 90 days of the denial of rehearing. This court has jurisdiction over this case pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The statutes involved in this case are the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, the McCarran-Ferguson Act, 15 U.S.C. § 1101 *et seq.*, and Virginia Code § 38.2-3407 (1993), the respective relevant provisions of which are set out at App. 33a-34a.

STATEMENT OF THE CASE

The preferred provider organization ("PPO") is a system by which employee benefit plans deliver health care to plan participants at a reduced cost. This case presents an important question whether ERISA's broad preemption of state laws "relating to" employee benefit plans nonetheless tolerates state regulation of the membership of PPOs because PPO membership constitutes the "business of insurance."

PPO administrators customarily contract with a limited network of "preferred" health care providers for

the provision of health care services to employee benefit plan subscribers at substantial discounts. The cost savings afforded by a PPO are made possible by ensuring increased patient volume for preferred providers. Employee benefit plan participants who choose PPOs are given financial incentives to use preferred rather than nonpreferred providers; participants typically are reimbursed for a greater percentage of the cost of treatment by a preferred provider. This practice results in a relatively greater number of patients for preferred providers. Increased patient volume allows the preferred providers to lower their per patient costs, which, in turn, permits the providers to discount their fees. Some limitation on PPO membership thus is necessary to enable the preferred providers to receive an increase in patient volume sufficient to warrant the reduction in fees. The broader the PPO network, the less likely it is that the preferred providers each will experience the necessary increase in patient volume.

The PPO arrangement itself is only a contract between a PPO administrator and health care providers. The contract does not address what health care services are covered under an employee benefit plan, but only the discounted fees that the providers will charge for treating plan participants. The PPO administrator may not even be an insurance company. The method by which a PPO is offered in an employee benefit plan may or may not involve a contract of insurance; the employer may purchase insurance to pay for the PPO service, or may pay the PPO costs as they are incurred.

Virginia Code § 38.2-3407 regulates the membership in PPOs offered or administered by an insurance com-

pany. Like similar laws in many other states, this "any willing provider" statute mandates that no health care provider willing to meet the terms and conditions of such a PPO may be excluded from the organization.[1] This proscription, on its face, applies even when the insurance company is acting only as administrator, and is not also insuring payment of covered services.

Aetna Life Insurance Company variously administers and insures employee benefit plans in the Richmond, Virginia area. Aetna Health Management maintains and manages the PPO that Aetna Life Insurance Company established in the Richmond area. Some of the employee health benefit plans subscribing to Aetna's Richmond-area PPO are self-insured; in those instances, Aetna provides only administrative services.

Respondent Stuart Circle Hospital Corporation ("Stuart Circle") owns and operates a hospital in Richmond, Virginia. Stuart Circle sued Aetna in Virginia state court, alleging that Aetna had violated section 38.2-3407 by excluding Stuart Circle from Aetna's Richmond-area PPO. Aetna removed the case to the United States District Court for the Eastern District of Virginia under 28 U.S.C. § 1441(a), on grounds of diversity of citizenship.

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[1] Several states have mandatory provider laws of exactly the same form as that in Virginia. Other states have mandatory provider laws restricting PPO administrators' ability to contract freely with health care providers. See *infra* at n.2. The Fourth Circuit's decision in this case implicates the enforceability of each of these laws as they relate to employee benefit plans.

The district court later granted Aetna's motion for summary judgment, holding that section 38.2-3407 is preempted by the ERISA. App. 32a. Concluding first that the Virginia statute "relates to" employee benefit plans within the meaning of section 514(a) of ERISA, the district court held also that the statute is not saved from preemption by ERISA's insurance savings clause, section 514(b)(2)(A), which excepts from preemption state laws that "regulate insurance." App. 24a, 31a-32a. The district court recognized that the question whether a state law "regulates insurance" under ERISA is to be determined by the same criteria used to establish whether a state law regulates the "business of insurance" under the McCarran-Ferguson Act. App. 24a. Relying primarily on this Court's decision in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), *cert. denied*, 469 U.S. 1160 (1985) the district court held that section 38.2-3407 does not regulate the "business of insurance," but only the business of insurance companies. In *Royal Drug*, the Court held that a service arrangement between a health insurer and a group of pharmacies that affected the insured indirectly by limiting available pharmacies is not the "business of insurance." Similarly, the district court here concluded that the PPO mechanism the Virginia statute regulates is merely a cost-saving arrangement between an insurer and service providers; it does not involve the transfer of risk between an insurer and an insured, the essence of the "business of insurance." App. 27a-29a.

A panel of the Fourth Circuit reversed. App. 3a-13a. Although agreeing that section 38.2-3407 "relates to" employee benefit plans, App. 7a, the Fourth

Circuit held that the Virginia statute is saved from preemption as a law that regulates the "business of insurance." App. 9a. Relying on *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), the Fourth Circuit first concluded that section 38.2-3407 regulates the "business of insurance" under a "common-sense" approach because it regulates, "albeit indirectly," "the relationship between insurer and insured [and] the type of policy which could be issued." App. 9a.

The Fourth Circuit held also that the Virginia statute regulates the "business of insurance" under the three criteria developed under the McCarran-Ferguson Act. According to the court, PPO arrangements have the effect of "transferring or spreading the policyholder's risk" that service will not be provided by the doctor or hospital of the policyholder's choice, PPOs are "an integral part of the policy relationship between the insurer and the insured," and the Virginia statue is "expressly 'limited to entities within the insurance industry.'" App. 9a-11a.

Aetna petitioned the Fourth Circuit for rehearing and suggested rehearing in banc. Aetna explained that the Fourth Circuit's decision is contrary to *Royal Drug* and to the Fourth Circuit's own decision in *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (1980), *cert. denied*, 450 U.S. 916 (1981). Following the rule of *Royal Drug*, the Fourth Circuit in *Virginia Academy* held that an insurance company practice of not reimbursing the cost of services from certain health care providers is not the "business of insurance," because it addresses only who provides covered services, not what health services are covered. 624 F.2d at 484.

On July 1, 1993, the Fourth Circuit denied Aetna's rehearing petition without further explanation. App. 1a-2a. On August 11, 1993, the district court granted Aetna's motion to stay proceedings in this case pending this Court's disposition of the petition for writ of certiorari.

REASONS FOR GRANTING THE WRIT

The question presented by this petition is of extraordinary importance. The Fourth Circuit adopted an improperly broad conception of the "business of insurance" under the ERISA insurance savings clause, and thereby let stand a Virginia law that undermines the economic value of the preferred provider organization, a vital element in the efficient delivery of employee health care. The PPO mechanism will work to lower the cost of health care only if the pool of providers in the organization is limited. The Virginia "any willing provider" statute eliminates the cost savings available through this efficient mechanism for delivering health care to employee benefit plans by mandating the inclusion of certain providers in PPO networks. The Fourth Circuit's decision accepts the present patchwork of state mandatory provider laws, to the serious detriment of employee benefit plan participants. The Virginia statute is precisely the type of costly state regulation that ERISA was intended to preempt. Federal authorities regularly have condemned such laws as anticonsumer and anticompetitive.

The Fourth Circuit's resolution of the key "business of insurance" issue is directly contrary to this Court's decision in *Royal Drug* and is inconsistent with the Third Circuit's recent decision in *Ticor Title Ins. Co.*

v. FTC, 998 F.2d 1129 (3d Cir. 1993). *Royal Drug* teaches that a practice constitutes the "business of insurance" only if it involves the underwriting of risk, and that an insurance company service arrangement that has only an indirect effect on insurance benefits is not the "business of insurance." *Ticor* is to the same effect. The Fourth Circuit failed to recognize the crucial distinction between the underwriting of risk and the much broader category of insurance company practices that may have some effect on the insured. The arrangement of a PPO is nothing more than a service contract between a PPO administrator and health care providers; it is not a contract of insurance, and does not affect the risk of treatment underwritten in a health insurance contract.

The Fourth Circuit's misapplication of ERISA preemption principles creates extraordinary costs for employee benefit plan participants. Supreme Court review is necessary to reverse this unfortunate ruling.

A. The Fourth Circuit's Decision Will Have Profound Adverse Consequences for the Efficient Delivery of Health Care, in Direct Contravention of the ERISA Mandate

By upholding state authority to regulate employee benefit plans in contradiction of ERISA's preemptive mandate, the Fourth Circuit's decision seriously impairs the efficient delivery of health care to employee benefit plan participants. ERISA preemption establishes employee benefit plan regulation "as an area of exclusive federal concern." *FMC Corp. v. Holliday*, 111 S. Ct. 403, 407 (1990). Recognizing that the "economic impact of [employee benefit plans] is increasingly interstate," and that the "soundness and stability of plans with respect to adequate funds to

pay promised benefits may be endangered," Congress in ERISA sought to relieve employee benefit plans of the inefficiencies of having to comply with often conflicting state regulation. See 29 U.S.C. § 1001(a); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987). Accordingly, under ERISA § 514(a), any state law that "relates to" an employee benefit plan gives way, unless it fits within one of the "very limited exceptions to preemption" contained in the ERISA savings clause, section 514(b). *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 104 (1983).

ERISA preempts not only state laws on subject matters covered by ERISA, but state laws that have any "connection with or reference to" an employee benefit plan. *Id.* at 96-97. ERISA preempts the field; where ERISA does not regulate a certain aspect of employee benefits, the area is to be free from regulation under both ERISA and state law. *Id.* at 98-99. The resulting "regulatory void" in certain areas evinces congressional intent to leave those subjects to the discretion of benefit plan designers and labor-management negotiations. *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981). Thus, ERISA places few restrictions on the delivery of employee welfare benefits, like health care, allowing instead for broad ranging innovation and ready adaptation to changing circumstances. *See* 29 U.S.C. § 1051(1) (exempting welfare plans from participation and vesting requirements applicable to pension plans); 29 U.S.C. § 1081(1) (exempting welfare plans from funding requirements applicable to pension plans). "[M]edical insurance must take account of inflation, changes in medical practice and technology, and increases in the

costs of treatment independent of inflation." *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988).

The Fourth Circuit's decision in this case permits the very state regulation of employee health plans that ERISA preempts. The PPO is precisely the kind of market-driven health care innovation Congress encouraged through ERISA. Yet, state regulation of PPOs presently is a patchwork of requirements and prohibitions, with numerous states imposing different mandates on the providers that must be included in a PPO arrangement.[2] The diversity of this legislation

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[2] The requirements vary widely. Several states in addition to Virginia impose a requirement that any provider willing to meet the terms and conditions of the PPO must be allowed in the network. E.g., Ga. Code Ann. § 33-20-16 (1990); 215 Ill. Comp. Stat. Ann. 5/370h (1993); Ind. Code Ann. § 27-8-11-3 (Burns 1992); La. Rev. Stat. Ann. § 40:2202 (West 1992); Utah Code Ann. § 31A-22-617 (1991); Wyo. Stat. § 26-22-503 (1977). The any willing provider requirements in some states apply to all health care providers, while in other states the law is limited to physicians only, excluding institutional providers. E.g., 215 Ill. Comp. Stat. Ann. 5/370h; La. Rev. Stat. Ann. § 40:2202. In still other states, the law applies only to pharmacy arrangements. E.g., Ala. Code § 27-45-3 (Supp. 1993); Idaho Code § 41-1844 (1991); S.D. Codified Laws Ann. § 58-18-37 (1990); Wis. Stat. Ann. § 628.36 (1991 & Supp. 1992). Numerous states mandate inclusion of certain types of providers (e.g., chiropractors, podiatrists) in PPOs. E.g., Neb. Rev. Stat. § 44-4112 (1988); Nev. Rev. Stat. Ann. §§ 695C.177, 695C.178 (1986); W.Va. Code § 33-25A-31 (1992). Overlaid on these disparate statutory requirements are regulations in the various states that may impose additional requirements or otherwise give specific meaning to the often indeterminate language of statutes. E.g., Ark. Ins. Comm. Bulletin 9-85 & 9-85A (1985) (interpreting Arkansas statute as an any willing provider law). State court decisions in-

is the result of successful lobbying efforts by service providers seeking inclusion in PPOs. Elizabeth S. Rolph, et al., *State Laws and Regulations Governing Preferred Provider Organizations* 38-40 (Rand 1986). Employee benefit plan administrators, who frequently administer plans that operate across state lines, must conform their contractual arrangements to the requirements of these myriad states laws.

This panoply of regulation has a profound effect on the operation of employee benefit plans. In 1992, nearly 40 percent of all employers nationwide offered their employees some form of PPO; almost 58 million employees and their dependents participated in these programs. American Association of Preferred Provider Organizations, "PPO Growth" (1993). Requiring PPO administrators to conform to overabundant state regulation will increase costs, and those costs will be felt by this multitude of employee benefit plan participants. It is to avoid just this result that ERISA preempts state regulation of benefit plans:

> A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Pre-emption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.

Fort Halifax, 482 U.S. at 11.

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terpreting statutes and regulations also add to the multiple diverse rules to which employee benefit plan sponsors must adhere.

Beyond the inefficiencies of compliance with such a "patchwork scheme of regulation," the substance of the any willing provider laws that the Fourth Circuit decision affirms would be costly for employee benefit plan participants even if all states had identical laws. The key to the PPO arrangement is the substantial cost discounts made possible by the limitation of providers in the organization. Providers are able to reduce their fees for services offered through the PPO because the limited size of the PPO insures each provider a sufficient volume of patients to warrant the fee reductions. Increased patient volume from a single PPO creates economies of scale, reduces marketing costs, and reduces transaction costs as providers deal with fewer third-party payors. Limited PPO panels also reduce costs to the PPO administrator by lowering administrative costs and making possible more efficient utilization and peer review programs by which sponsors monitor provider behavior. *See* Rolph, et al., *supra* at 46-47; *Report to Health Insurance Association of America: Cost Analysis of State Legislative Mandates on Six Managed Health Care Practices* 14-26 (Wyatt Co. 1991). Employee health plan participants benefit from all of these savings.

Limited-membership PPOs also reduce costs and improve services by creating competition between providers. When PPO administrators are able to negotiate freely with service providers, they can create more efficient PPO arrangements and more favorable terms for plan participants by placing providers in competition for inclusion in the PPO. *See* Lori A. Tobias, *Cost v. Quality in the Regulation of Preferred Provider Arrangements: A "Green Light to the Gold Rush"?*, 41 Sw. L.J. 1155, 1187-1190 (1988); G.A.

Melnick, et al., *The Effects of Market Structure and Bargaining Position on Hospital Prices*, 11 J. Health Econ. 217 (1992). Moreover, the existence of multiple limited-size PPO plans gives a choice to the consumers of such plans. The resulting competition reduces costs and spurs innovation:

> The most important feature of the plans in stimulating competition is that they distinguish between specific sets of physicians and hospitals, with a separate premium for each. The consumer picking the more efficient set of providers is rewarded by a lower premium and/or greater benefits. The attractive and efficient provider groupings are regarded by enrollment growth. In this way incentives for cost consciousness on the part of providers and consumers are created.

Jon B. Christianson & Walter McClure, *Developing a Regulatory Strategy Consistent with a Competitive Health Care System*, in *Socioeconomic Issues of Health* 104 (Douglas E. Hough & Glen I. Misek eds., 1980). *See also* David Dranove, et al., *Is Hospital Competition Wasteful?*, 23 RAND J. Econ. 247 (Summer 1992).

The forced expansion of PPO provider membership through any willing provider laws undermines all of these salutary effects and increases dramatically both the cost of administration and the cost of claims made by employee benefit plan participants. A 1991 study by the Wyatt Company estimated that any willing provider laws increase PPO administrative costs between 34 and 52 percent, and increase the cost of claims between 8.8 and 14.2 percent. *Report to Health*

Insurance Association of America at 15-16, 19-20. The study concluded that if a large number of providers choose to join a PPO pursuant to any willing provider legislation, the "legislative mandate would eliminate the value of the PPO to the community." *Id.* at 5. It is, consequently, not surprising that a 1986 survey of PPO sponsors found that mandatory provider laws posed the most serious of all possible regulatory threats to the effective operation of PPOs. Elizabeth S. Rolph, Paul B. Ginsburg & Susan D. Hosek, *The Regulation of Preferred Provider Organizations*, 6 Health Affairs 32, 40 (Fall 1987).

Any willing provider laws also impair competition between service providers, to the detriment of consumers. The Federal Trade Commission has for over a decade objected to mandatory provider laws as anticompetitive and anticonsumer. Attached (App. 35a-43a) is a recent letter from the Acting Director of the FTC's Office of Consumer and Competition Advocacy to the Attorney General of the State of Montana.[3] The letter details the FTC's objections to Montana's any willing provider statute, reaffirming all of the cost and competition effects discussed above. (The Montana mandatory provider law, which was allowed to sunset in July of this year, is virtually identical to the Virginia law at issue here.) The Acting Director explains the competitive importance of limited-provider panels and the anticompetitive, anticonsumer effect of any willing provider requirements. The letter also describes the FTC's long-standing public objection—including congressional testimony, com-

[3] Petitioners ask the Court to take judicial notice of this matter of public record.

ment letters to state legislators and agencies, and litigation[4]—to efforts to suppress selective contracting with a limited panel of health care providers. App. 36a-37a. The FTC's opposition to any willing provider laws underscores the importance of the issue in this case to health care consumers.

B. The Fourth Circuit's Decision is Directly Contrary to Supreme Court Authority and Is Inconsistent with the Third Circuit's Recent Decision in *Ticor Title Ins. Co. v. FTC*

The ERISA insurance savings clause saves from preemption any state law "which regulates insurance." 29 U.S.C. § 1144(b). Whether a practice constitutes "insurance" under ERISA is determined by the same criteria used to determine the "business of insurance" saved from federal antitrust regulation under the McCarran-Ferguson Act. *Pilot Life*, 481 U.S. at 48-49; *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1983).[5] The Virginia mandatory

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[4] The FTC has instituted a series of law enforcement actions to prevent private anti-competitive arrangements that suppress or eliminate selective contracting. See, e.g., *Medical Service Corp. of Spokane County*, 88 F.T.C. 906 (1976); *American Medical Association*, 94 F.T.C. 701 (1979) *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court*, 455 U.S. 676 (1982); *Eugene M. Addison, M.D.*, 111 F.T.C. 339 (1988). See generally App. 36a-37a. These private arrangements have the same effect as any willing provider laws.

[5] The ERISA insurance savings clause and the McCarran-Ferguson Act each carves out an exception to federal regulation for the "business of insurance," leaving the regulation of such activity to the states. *Metropolitan Life*, 471 U.S. at 744 n.21. Because the two statutes "utilize similar language to define what is left to the States," the Court has treated the definition of the "business of insurance" as essentially the same under ER-

provider statute regulates the contractual relationship between PPO administrators and medical service providers. The Fourth Circuit held that these service contracts constitute the "business of insurance," and therefore that the Virginia statute is excepted from ERISA preemption. The court thereby contravened controlling Supreme Court authority on the "business of insurance," and placed itself in conflict on this issue with the Third Circuit.

1. The Fourth Circuit Failed to Heed the Lesson of *Royal Drug* that the Selection of Service Providers Is Not the "Business of Insurance."

The key to the "business of insurance" is the underwriting of risk. *SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65, 73 (1959) ("underwriting of risks [is] the one earmark of insurance"). With health insurance, that risk is the treatment of illness or injury. A PPO, on the other hand, is a noninsurance contractual arrangement that deals only with *who* will provide treatment for the injury or illness covered by an employee benefit plan, and not what services are covered. It is a way of organizing the efficient delivery of medical benefits that is completely independent of the risk that a benefit plan participant will be reimbursed for the treatment of any particular illness or injury.

The Fourth Circuit failed to recognize the crucial distinction between the underwriting of risk and the much broader category of insurance company practices that may have some effect on the insured. Specifically, the court held that the "several components

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ISA and McCarran-Ferguson. *Id.* at 742-44 & n.21; *Pilot Life*, 481 U.S. at 48-49.

to the 'policyholder's risk'" include the risk of not being able to use the health care provider of the policyholder's choice." App. 9a-10a. The court explained that, by expanding the pool of available providers (at least in theory), the Virginia statute forces insurers to underwrite more of this risk. App. 10a. Therefore, according to the Fourth Circuit, the statute regulates the "business of insurance," even though this element of "risk" has nothing to do with whether a benefit plan provides coverage for the treatment of any particular illness or injury.

That conclusion is directly contrary to this Court's decision in *Royal Drug*. The precise issue in that case, as in this one, was whether a limitation on the preferred *providers* of a medical service, without a limitation on covered *services*, constitutes the business of insurance. The Court held that cost-saving arrangements that restrict the provider of services, but not the services rendered, are not the "business of insurance."

In *Royal Drug*, a Blue Shield insurance company offered policies entitling the insured to purchase prescription drugs for $2 from any pharmacy participating in a "Pharmacy Agreement" with Blue Shield. Participating pharmacies were required to sell drugs to Blue Shield's policyholders for $2, and were reimbursed only for their cost in acquiring the drug. The arrangement was, in essence, a PPO for pharmacies.

A group of independent pharmacists brought an antitrust action against Blue Shield, which defended on the ground that the pharmacy agreements qualified as the "business of insurance" under the McCarran-Ferguson Act and therefore were exempt from the federal antitrust laws. The Court concluded that the

agreements did not constitute the "business of insurance" because they did not have the effect of transferring or spreading a policyholder's risk. 440 U.S. at 214. The agreements served "only to minimize the costs Blue Shield incurs in fulfilling its underwriting obligations," *id.* at 213, and while "[s]uch cost-savings arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums . . . they are not the 'business of insurance.'" *Id.* at 214.

Much like respondents here, petitioners in *Royal Drug* argued that the Pharmacy Agreements constituted the "business of insurance" because they "closely affect" the insurance contract. 440 U.S. at 216. That argument "proves too much," however. *Id.* By that way of thinking, the Court explained, any business decision by an insurance company that may affect the insurance contract would constitute the "business of insurance." The McCarran-Ferguson Act (and consequently ERISA) exempts the "business of insurance," not the "business of insurance companies." *Id.*

The present case is legally indistinguishable from *Royal Drug*. Aetna's PPO arrangements are cost-saving measures independent of the relationship between insurer and insured; they are contracts between Aetna and service providers, exactly like the Pharmacy Agreements in *Royal Drug*. Those service contracts do not involve the underwriting of risk, and therefore do not constitute the "business of insurance."

The Fourth Circuit nonetheless maintained that PPO arrangements have the effect of "transferring or spreading the policyholder's risk" that service will

not be provided by the doctor or hospital of the policyholder's choice. App. 10a. This Court rejected a similar assertion from petitioners in *Royal Drug*. The Court made clear that such service contracts do not affect a policyholder's "risk":

> The fallacy of the petitioners' position is that they confuse the obligations of Blue Shield under its insurance policies, which insure against the risk that policyholders will be unable to pay for prescription drugs during the period of coverage, and the agreements between Blue Shield and the participating pharmacies . . . . The benefit promised to Blue Shield policyholders is that their premiums will cover the cost of prescription drugs except for a $2 charge for each prescription.

440 U.S. at 213-24. The benefit promised plan participants in this case is that treatment for illness and injury will be paid for at a prescribed rate, not that they will be able to use any doctor or hospital.[6]

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[6] This Court's recent decisions in *United States Dept. of Treasury v. Fabe*, 113 S. Ct. 2202 (1993), and *Hartford Fire Ins. Co. v. California*, 113 S. Ct. 2891, *cert. denied sub nom.* 113 S. Ct. 3034 (1993), reaffirm *Royal Drug* and emphasize the Fourth Circuit's misapplication of Supreme Court authority. In *Fabe*, the Court held that an Ohio law specifying the priority of claims in proceedings to liquidate an insurance company regulated the "business of insurance" because the statute affected directly the payment of the contracted for insurance benefits. The Court distinguished *Royal Drug*, explaining that the service contracts at issue there were "ancillary activities" with insufficient connection to the obligations of the insurance contract. *Id.* at 2209. So, too, are PPO arrangements.

In *Hartford Fire*, the Court reaffirmed the distinction be-

The Fourth Circuit attempted to distinguish *Royal Drug* on the ground that "[t]he practice at issue in *Royal Drug*, unlike Aetna's PPO, did not restrict the availability of benefits to insureds because any pharmacy which agreed to the insurance company's terms was allowed to participate." App. 12a. The factual premise is incorrect. The practice at issue in *Royal Drug* clearly *did* restrict the availability of benefits to the insured, because not all pharmacies were willing to meet the price requirements necessary to participate—hence the lawsuit. More important, this Court made clear in *Royal Drug* that the open access of pharmacies to the Pharmacy Agreements was irrelevant to its decision. The result would be the same, the Court explained, if "an insurance company entered into a contract with a large retail drug chain whereby its policyholders could obtain drugs under their policies only from stores operated by this chain." 440 U.S. at 215. Such an arrangement, which would require the policyholder to "shoulder all or part th[e] cost when seeking [drugs] from an excluded [pharmacy] of his or her choice," App. 10a, is not the

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tween the "business of insurance" and the "business of insurance companies": " 'the business of insurance' should be read to single out one activity from others, not to distinguish one entity from another." 113 S. Ct. at 2901. Regarding insurance company contracts, the Court explained that "agreements that insurance companies ma[k]e with 'parties wholly outside the insurance industry,' . . . such as the retail pharmacists involved in *Royal Drug* . . . are unlikely to be about anything that could be called 'the business of insurance,' as distinct from the broader " 'business of insurance companies.' " *Id.* at 2902 (quoting *Royal Drug*, 440 U.S. at 232, 233). The arrangement of a PPO is a contract with medical service providers independent of insurance; it does not become the "business of insurance" because it is engaged in by an insurance company.

"business of insurance." A fortiori, the arrangement at issue in this case, which also might require the policyholder to "shoulder" the cost of seeking treatment from a doctor or hospital not included in Aetna's PPO, is not the "business of insurance."

The Fourth Circuit concluded that it could disregard *Royal Drug* because this Court did not rely on *Royal Drug* in *Metropolitan Life*. App. 12a. *Metropolitan Life* is, however, clearly distinguishable from *Royal Drug* and this case. *Metropolitan Life* involved a Massachusetts law that mandated insurance coverage for the treatment of mental illness. The Court held that this mandatory *benefit* law regulated the "business of insurance" under the ERISA insurance savings clause precisely because the law affected the insured's risk of treatment by mandating the health services covered. 471 U.S. at 743. This case involves a mandatory *provider* law fundamentally different from the mandatory benefit law at issue in *Metropolitan Life* and identical in all material respects to the mandatory provider arrangement in *Royal Drug*. A mandatory benefit law specifies the health care coverage that must be included in an insurance contract. Mandatory provider laws, on the other hand, say nothing about required services, but specify only who must be paid if certain services are covered.

By reading the "business of insurance" to include essentially all insurance company activity that somehow affects the insured, in contravention of Supreme Court authority, the Fourth Circuit's decision opens the door to inconsistent and inefficient state regulation of a wide variety of benefit plan cost-saving measures. *All* insurance company contracts with sup-

pliers of goods and services affect the costs associated with employee benefit insurance programs. The great danger of the Fourth Circuit's decision is that it allows stifling state regulation not only of PPOs, but of health maintenance organizations ("HMOs"), point-of-service arrangements, and a host of yet undeveloped mechanisms for the efficient delivery of health care. That is why ERISA preempts state laws that do not directly regulate the underwriting of risk. Moreover, the Fourth Circuit's unwarranted expansive definition of the "business of insurance" also may insulate from federal antitrust regulation the practices mandated by any willing provider laws, despite their undeniable anticompetitive and anticonsumer consequences.[7]

2. The Fourth Circuit's Decision Is in Conflict with the Third Circuit's Decision in *Ticor* in Its Reading of the "Business of Insurance."

The Fourth Circuit's overly-broad conception of the "business of insurance" is in clear conflict with the understanding of the Third Circuit in *Ticor Title Ins. Co. v. FTC*, 998 F.2d 1129 (3d Cir. 1993). That case, on remand from this Court, involved an antitrust challenge to certain title insurance company practices concerning title search and examination services. The Third Circuit concluded that these practices are not immune from antitrust scrutiny pursuant to the McCarran-Ferguson Act because title search and examination services performed by or for a title insur-

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[7] Because the definition of the "business of insurance" is identical under ERISA and the McCarran-Ferguson Act, the construction of that phrase adopted in a case under one statute is relevant to both. *Metropolitan Life*, 471 U.S. at 742-44; *Pilot Life*, 481 U.S. at 48-49.

ance company are not themselves the "business of insurance."

The "critical fact" supporting the Third Circuit's determination was that this service arrangement "does not itself spread or transfer risk." *Id.* at 1134. The Third Circuit found title search and examination analogous to the Pharmacy Agreements in *Royal Drug*, in that it has nothing to do with the actual performance of the insurance contract. *Id.* at 1136.[8] That title search might have an indirect effect on the course of conduct between the insurance company and insured is insufficient to bring the practice within the "business of insurance": "Following the lead of *Royal Drug*, we too reject the notion that the indirect effects of the title search and examination process on the business of title insurance are sufficient to merit protection from antitrust liability under section 2(b)." *Id.* at 1137. This conclusion is in stark contrast to the Fourth Circuit's holding in this case that the Vir-

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[8] In this regard, the Fifth Circuit's recent decision in *Tingle v. Pacific Mutual Ins. Co.*, 996 F.2d 105 (1993), is consistent with *Ticor* and *Royal Drug*, and inconsistent with the Fourth Circuit's decision in this case. The *Tingle* court held that a Louisiana law regarding representations made in health insurance applications is preempted by ERISA because it "relates to" employee welfare plans, and is not saved as a law that "regulates insurance." Acknowledging that the state law regulates insurance practices, and that it might fit a common-sense definition of the regulation of insurance, the court nonetheless concluded that the law does not regulate the "business of insurance" because it does "not act to spread policyholder risk." *Id.* at 108. "[T]he statute . . . does not spread the risk of insurance (health) coverage for which the parties contracted." *Id.* The same is true of the PPO, which does not affect the insured's risk of treatment for illness or injury.

ginia statute regulates the business of insurance because it affects the insurer-insured relationship, "albeit indirectly." App. 9a.

In short, the PPO arrangements at issue here are legally indistinguishable from the Pharmacy Agreements at issue in *Royal Drug*, and analogous to the title search and examination services at issue in *Ticor*. The result in all three cases should have been the same.

C. The Issue in This Case is Too Important to Wait for a Direct Split of Lower Court Authority

The Fourth Circuit declared that its decision regarding the "business of insurance" is consistent with decisions from two state courts and the Tenth Circuit regarding mandatory provider laws. App. 13a. None of those decisions can be reconciled with *Royal Drug* however.[9] They are further evidence of the dangerous

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[9] The statute at issue in *Blue Cross and Blue Shield of Kansas City v. Bell*, 798 F.2d 1331 (10th Cir. 1986), mandated payment for the services of particular types of health care providers. In holding that the statute regulates the "business of insurance," the Tenth Circuit made the same error as the Fourth Circuit here: the court there concluded that choice of provider is part of the transferred risk in a health insurance contract. *Id.* at 1335.

Blue Cross Hospital Service of Missouri v. Frappier, 698 S.W.2d 326 (Mo. 1985), also involved a statute requiring insurers to cover the services of particular types of providers, and to reimburse the cost of drugs from pharmacists whether or not they have a contract with the insurer. The Missouri Supreme Court misunderstood *Royal Drug* when it declared that there is no distinction between the mandated benefit provisions in *Metropolitan Life* and mandated provider statutes. The pharmacy provision in *Frappier*, in particular, regulates precisely the same

misunderstanding abroad about the "business of insurance" that this Court should set right.

The Fourth Circuit went to great lengths to avoid a conflict with these cases. In doing so, the court not only fundamentally misread *Royal Drug*, but it failed even to cite a prior Fourth Circuit decision directly on point. In *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981), an organization of clinical psychologists brought a Sherman Act antitrust suit against two Blue Shield health benefit plans based upon the plans' failure to pay for services rendered by certain psychologists. The Fourth Circuit concluded that the defendants' conduct was not the "business of insurance." Following *Royal Drug*, the Fourth Circuit in *Virginia Academy* explained that the "business of insurance" involves the risk that the insured will receive certain services, not the risk that the insured will receive service from a particular provider: "[The Blue Shield] decision regarding psychologists was not *whether* to underwrite the risk of those disorders or even the need for psychotherapy; rather it was a question of *who* they would pay for such services. The coverage remained the same." 624 F.2d at 484 (emphasis added). The Virginia statute at issue in this case also does not

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activity at issue in *Royal Drug*.

Blue Cross and Blue Shield of Virginia v. St. Mary's Hospital of Richmond, 245 Va. 24, 426 S.E.2d 117 (1993), presented exactly the same question as this case relevant to the same Virginia statute. The Virginia Supreme Court relied entirely on *Metropolitan Life* with little analysis. The court did not recognize that the Virginia statute is not a mandatory benefits law, and did not cite or discuss *Royal Drug*.

purport to regulate *whether* an insurance company must pay for the treatment of any illness or injury, but only *who* the insurance company must pay for such services.

That the Fourth Circuit in this case ignored completely *Virginia Academy*, despite copious citation by petitioners, in order to come in line with other courts is one indication that a split of authority may never arise on the precise issue in this case. Without guidance from this Court, other courts confronting mandatory provider laws can be expected to fall in line. In the meantime, as courts continue to apply an improper conception of the "business of insurance," employee benefit plans in Virginia and elsewhere will be prevented from responding efficiently to soaring health care costs, and benefit plan participants will suffer because of anticompetitive any willing provider laws. The issue is too important to wait for a lower court finally to get it right.

CONCLUSION

For the foregoing reasons, the Court should grant this petition and set the case for plenary review.

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Respectfully submitted,

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